

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No.

9627

1061

Registration District No. 399

Primary Registration District No. 1002

## 1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town Kansas City  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
K.C. General Hospital No. 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 9 days  
 (Specify whether  
 In this community Unknown  
 years, months or days)

3. (a) PRINT  
FULL NAMEHENRY KRAMER

8. (b) If veteran,  
name war

No

3. (c) Social Security  
No. NO

4. Sex Male

5. Color, or  
race W

6. (a) Single, widowed, married,  
divorced Widower

6. (b) Name of husband or wife  
Sarah Kramer

6. (c) Age of husband or wife if  
alive years

7. Birth date of deceased Sept. 16th, 1868  
 (Month) (Day) (Year)

## 8. AGE:

Years  
71

Months  
5

Days  
18

If less than one day

hr. min.

9. Birthplace Ill.  
 (City, town, or county) (State or foreign country)

## 10. Usual occupation

Farmer (Retired)

## 11. Industry or business

12. Name Peter Kramer

13. Birthplace Germany  
 (City, town, or county) (State or foreign country)

14. Maiden name Broder

15. Birthplace Germany  
 (City, town, or county) (State or foreign country)

## 16. (a) Informant's own signature

Mrs. Eva Cook

## (b) Address

3940 Norton

17. (a) Removal  
 (Burial, cremation, or removal)

(b) Date thereof 3/7/40  
 (Month) (Day) (Year)

## (c) Place: burial or cremation

Ackley Iowa

## 18. (a) Signature of funeral director

W. A. Mayberry

## (b) Address

2315 Linwood

19. (a) Mar 7, 1940  
 (Date received local registrar)

(b) M. M. Crane  
 (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
 (c) City or town Kansas City  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 541 1/2 Walnut St.  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 5th  
 year 1940 hour 1 minute 00 A. M.

21. I hereby certify that I attended the deceased from  
3-3-40, 19  , to 3-5-40, 19  ;

that I last saw him alive on 3-5-40, 19  ;  
 and that death occurred on the date and hour stated above.

Immediate cause of death  
Fibrous hypertrophic myocarditis;  
coronary occlusion

Due to

Due to

Other conditions Chronic vascular nephritis  
 (Include pregnancy within 3 months of death)

Major findings:  
 Of operations 131

Of autopsy See above

## 22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)  
 (b) Date of occurrence  
 (c) Where did injury occur? (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (c) Means of injury

23. Signature Supt. K.C. Gen. Hospital, K.C. Mo. (M. D. or other)  
 Address    Date signed

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*Ray E. Snow*

Licensed Embalmer No..... 2560

P. O. Address..... 2315 Linwood Blvd.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**